DOH-1901 (8/2011) No. 9702

REGISTER NUMBER 336

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL REGISTRAR COPY

RESIDENCE | NCHS | 4C | 4G | 7A | 7B | SI | 25 | 30 | 31 | 31B | QR | QS | QCOD | CANCER

DECEDENT

1. NAME: FIRST: Ronald MIDDLE: D. LAST: Smith
2. SEX: MALE [X] 1 FEMALE [ ] 2
3A. DATE OF DEATH: MONTH 12 DAY 05 YEAR 2016
3B. HOUR: 10:02 pm

4A. PLACE OF DEATH: (Check one) HOSPITAL DOA [ ] ER [ ] HOSPITAL OUTPATIENT [ ] HOSPITAL INPATIENT [ ] NURSING HOME [X] PRIVATE RESIDENCE [ ] HOSPICE FACILITY [ ] OTHER (Specify): [ ]
4B. IF FACILITY, DATE ADMITTED: MONTH 08 DAY 16 YEAR 2016
4C. NAME OF FACILITY: (If not facility, give address) St. Luke Health Services
4D. LOCALITY: (Check one and specify) CITY [X] VILLAGE [ ] TOWN [ ] Oswego
4E. COUNTY OF DEATH: Oswego
4F. MEDICAL RECORD NO. A-7628
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO [ ] YES [X] University Hospital Syracuse NY Onondaga Co

5. DATE OF BIRTH: MONTH 05 DAY 17 YEAR 1984
6A. AGE IN YEARS: 32 yrs.
6B. IF UNDER 1 YEAR ENTER: months days
6C. IF UNDER 1 DAY ENTER: hours minutes
7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Oswego, NY
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO [X] 0 YES [ ] 1
9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.
A [X] No, not Spanish/Hispanic/Latino B [ ] Yes, Mexican, Mexican American, Chicano C [ ] Yes, Puerto Rican D [ ] Yes, Cuban E [ ] Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be:
A [X] White/Caucasian B [ ] Black or African American C [ ] Asian Indian D [ ] Chinese E [ ] Filipino F [ ] Japanese G [ ] Korean H [ ] Vietnamese J [ ] Native Hawaiian K [ ] Guamanian or Chamorro M [ ] Samoan N [ ] American Indian or Alaska Native (specify) P [ ] Other Asian (specify) R [ ] Other Pacific Islander (specify) S [ ] Other (specify)
11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death.
1 [ ] ≤ 8th grade 2 [ ] 9th-12th grade; no diploma 3 [X] High school graduate or GED 4 [ ] Some college credit, but no degree 5 [ ] Associate's degree 6 [ ] Bachelor's degree 7 [ ] Master's degree 8 [ ] Doctorate/Professional degree

12. SOCIAL SECURITY NUMBER: 405-27-2111
13. MARITAL STATUS: NEVER MARRIED [X] 1 MARRIED [ ] 2 WIDOWED [ ] 3 DIVORCED [ ] 4 SEPARATED [ ] 5
14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.
15A. USUAL OCCUPATION: (Do not enter retired) Certified nurse's aide
15B. KIND OF BUSINESS OR INDUSTRY: Healthcare
15C. NAME AND LOCALITY OF COMPANY OR FIRM: St. Luke Health Services Oswego NY
16A. RESIDENCE: (State or Country if not USA) NY
16B. County or Region/Province if not USA: Oswego
16C. LOCALITY: (Check one and specify) CITY [X] VILLAGE [ ] TOWN [ ] Fulton
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? [ ] YES [X] NO IF NO, SPECIFY TOWN: Volney
16D. STREET AND NUMBER OF RESIDENCE: 91 Kings Rd
16E. ZIP CODE: 13069

PARENTS

17. BIRTH NAME OF FATHER / PARENT: FIRST David MI LAST Smith
18. BIRTH NAME OF MOTHER / PARENT: FIRST Denise MI LAST Atkinson
19A. NAME OF INFORMANT: Denise Smith
19B. MAILING ADDRESS: (include zip code) 91 Kings Rd. Fulton, NY 13069

DISPOSITION

20A. 1 [ ] BURIAL 2 [X] CREMATION 3 [ ] REMOVAL 4 [ ] HOLD 5 [ ] DONATION 6 [ ] ENTOMBMENT MONTH 12 DAY 06 YEAR 2016
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Traub Crematorium
20C. LOCATION: (City or town and state) Central Square, NY
21A. NAME AND ADDRESS OF FUNERAL HOME: Sugar & Scanlon Funeral Home 147 W. 4th St. Oswego NY 13126
21B. REGISTRATION NUMBER: 01642
22A. NAME OF FUNERAL DIRECTOR: Theresa A. Sugar Scanlon
22B. SIGNATURE OF FUNERAL DIRECTOR: Theresa A. Sugar Scanlon
22C. REGISTRATION NUMBER: 13496
23A. SIGNATURE OF REGISTRAR: Rita A. Vora
23B. DATE FILED: MONTH Dec DAY 06 YEAR 2016
24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Rita A. Vora
24B. DATE ISSUED: MONTH Dec DAY 06 YEAR 2016

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: Sandra A. Ford N.P. License No.: 330672 Signature: Sandra A. Ford Month 12 Day 06 Year 2016
Certifier's Title: 0 [ ] Attending Physician 0 [ ] Physician acting on behalf of Attending Physician 1 [ ] Coroner 2 [ ] Medical Examiner / Deputy Medical Examiner
Address: 299 E. River Rd, Oswego NY 13126
25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: Month Day Year
25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address:
26A. Attending physician attended deceased: FROM 08 16 2016 TO 12 05 2016
26B. Deceased last seen alive by attending physician: 12 05 2016
26C. Pronounced Dead ON 12 05 2016 AT 2202 M
27. MANNER OF DEATH: NATURAL CAUSE [X] 1 ACCIDENT [ ] 2 HOMICIDE [ ] 3 SUICIDE [ ] 4 UNDETERMINED CIRCUMSTANCES [ ] 5 PENDING INVESTIGATION [ ] 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 [X] NO 1 [ ] YES
29A. AUTOPSY? NO [X] 0 YES [ ] 1 REFUSED [ ] 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 [ ] NO 1 [ ] YES

CONFIDENTIAL SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH CONFIDENTIAL

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. IMMEDIATE CAUSE (A) Respiratory arrest palliative care status — minutes
DUE TO OR AS A CONSEQUENCE OF: (B) AIDS — 3 yrs
DUE TO OR AS A CONSEQUENCE OF: (C)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): Asthma, HIV Encephalopathy
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 [X] NO 1 [ ] YES 2 [ ] PROBABLY 3 [ ] UNKNOWN
31A. IF INJURY, DATE: MONTH DAY YEAR HOUR: m
31B. INJURY LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO [ ] 0 YES [ ] 1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 [ ] Driver/Operator 2 [ ] Passenger 3 [ ] Pedestrian 4 [ ] OTHER (specify)
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO [X] 0 YES [ ] 1
33A. IF FEMALE: 0 [ ] Not pregnant within last year 1 [ ] Pregnant at time of death 2 [ ] Not pregnant, but pregnant within 42 days of death 3 [ ] Not pregnant, but pregnant 43 days to 1 year before death 4 [ ] Unknown if pregnant within past year
33B. DATE OF DELIVERY: MONTH DAY YEAR

For use by physician or institution: NAME OF DECEDENT: Smith, Ronald DATE OF DEATH: 12/05/2016 TIME OF DEATH: 2202 AM PM

THIS IS TO CERTIFY that the foregoing is a true and correct transcript of the Death **RECORD on file in the Office of the Registrar of VITAL STATISTICS of the City of Oswego, New York, and of the whole thereof.**

WITNESS MY HAND AND SEAL OF THE CITY OF OSWEGO, NEW YORK, this

20th **day of** October **20** 17

REGISTRAR
City of Oswego, New York